COMPASSUS®

HOME PARENTERAL NUTRITION (TPN) ORDER FORM

P: 888-386-0886 | F: 586-263-3306

PATIENT INFORMATION:

Fax completed form, insurance information and clinical documentation to 586-263-3306

Name: _____ ❒ Demos attached

DOB: _____

Sex: ❒ Male ❒ Female

Weight: _____ ❒ lbs ❒ kg

Height: _____

Line Access

❒ Port ❒ PICC ❒ Other

Lumens: ❒ 1 ❒ 2 ❒ 3

❒ Central Line needed

ORDER INFORMATION

Diagnosis/Indication for TPN therapy: _____ Date: _____

Rx Order: Compassus to provide Home Parenteral Nutrition (PN)/TPN Therapy

TPN MANAGEMENT - FOR CUSTOM CONSULT, CHECK THE BOX

❒ ***Check Please***

Compassus will provide evidence-based, customized home PN management to optimize patient outcomes. Checking the box authorizes Compassus to assess and write orders for the initial TPN formula and to make ongoing changes to the TPN prescription including adjustments to electrolytes and macronutrients, volume and daily infusion duration, lab order management, and home health coordination with subsequent notification to the treating provider.

Treating provider managed TPN - Compassus will not provide recommendations for changes. Please include your custom order form.

REQUIRED INFORMATION

Length of Need Statement (LON)

- ***MUST be included in a progress note and signed by the prescriber***
- ***Example of LON: "Due to patient's [condition], TPN is needed for [insert amount of time here]."***
- ***Medicare requires patient to have a permanent impairment considered long and indefinite in duration***
- ***Note: Medicare does recognize time frames such as "lifetime" as appropriate***
- ***Must also include enteral contraindication.***
- ***What prevents patient from having a feeding tube?***
- ***Must list cause of malabsorption.***

Fax order form along with face sheet to: _____

Main Pharmacy Number: _____

PROVIDER INFORMATION:

By signing this form and utilizing our services, you are authorizing *Compassus* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Patient Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

❒ Opt out of Compassus selecting site of care (if checked, please list site of care) _____

PREFERRED LOCATION:

City: _____ State: _____